City of San José Department of Parks, Recreation and Neighborhood Services
Office of Therapeutic Services

Physician Recommendation for Participation in Exercise Classes

Date: _____ For Class: Adapted Fitness

Physician's name: _____Phone: _____

_____ has registered to participate in an exercise program.

CLASS DESCRIPTION:
These classes provide aerobic exercise, resistance training and flexibility/ROM exercises for people with disabilities. Classes are conducted in a fitness facility equipped with free weights, weight and cardio machines. Programs are based on the participant's ability and health/fitness goals. Programs are staffed by Adapted Physical Activity and Therapeutic Recreation Specialists.

Is this individual currently taking any medication(s) that will affect his/her participation or exercise responses in this program? If yes, please identify the medication(s) and describe the effects.

Medication Effect

_____
_____
_____
_____
_____

Please indicate your recommendations for this individual's participation in the exercise class described above:

( ) I recommend participation without limitation.
( ) I recommend participation with the following limitations:

_____
_____
_____
_____

( ) I do not recommend participation.
( ) Please call me for specific recommendations.

_____ _____
Physician's signature Date

Please return this form to:

Office of Therapeutic Services
3369 Union Ave.
San Jose, CA. 95124
Phone: (408) 559-8553 Fax: (408) 559-1203